Testimony of Willard Mays, MA
To the Policy Committee
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Financing Barriers and Solutions
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My name is Willard Mays. I represent the National Association of State Mental Health Program Directors and the American Society on Aging on the National Coalition on Mental Health and Aging and am the immediate past chair of the Coalition. I am the Assistant Deputy Director for Public Policy for the state mental health authority in Indiana.

Unfortunately many current and proposed federal policies create significant barriers in moving mental health and substance abuse promising and evidence-based practices from research to actual provision of services to older adults. This is particularly true of the Medicare and Medicaid programs. Medicaid is by far the largest payer of institutional care of older adults with mental illnesses. Although, according to the Centers for Medicare and Medicaid Services (CMS), almost one-quarter of the nation's Medicaid budget in 1998 went to support nursing home care, numerous studies have found that the mental health needs of residents remain under-addressed and often unrecognized. The majority of the services provided are neither the result of assessments by, nor directly provided by, qualified mental health professionals. A 1999 DHHS report found that Medicaid funding policies actually discourage the provision of specialty mental health services in nursing homes.

While nursing home care is a mandated Medicaid service the provision of community-based mental health care is not and results in states having to navigate through a maze of options and waivers. The Institutions for Mental Diseases restrictions and the fluctuating level of care of persons with mental illness make it virtually impossible to develop a Home and Community-Based Services (HCBS) Waiver. At present only one state has a mental health specific waiver for persons over the age of 21. The basic problem, the cost neutrality requirement, could be addressed by comparing the annualized Medicaid cost of serving the individual in any setting, rather than an institutional setting, with the cost of serving the person through a waiver.

Medicare coverage of mental health services, including both institutional and community-based care' is also minimal. Although Medicare is the largest funding source for health care of older adults only slightly more than one half of one percent (0.57 %) of total Medicare expenditures are for mental health services (Bartels and Smyer, 2002), and less than one-half of one percent of expenditures are for non-institutionalized recipients (Colenda et al., 2002).

Those individuals that are eligible for both Medicare and Medicaid, known as "dual eligibles", represent another major problem. The complexity in coordination of benefits and inadequate reimbursement rates are resulting in providers dropping or reducing mental health services to these individuals. In Indiana I am aware of three mental health

providers that have either dropped their older adult practice entirely, or have refused to serve older clients unless they physically come to their office. This is a particular issue for nursing home residents and those who live in rural areas. When this is added to the current and projected shortage of qualified geriatric mental health and substance abuse professionals the word "crisis" is not an exaggeration. A study I did found that 64 of Indiana's 92 counties did not have a psychiatrist, 23 did not have a clinical psychologist while 21 others had only one.

An especially troubling immediate concern is the new Medicare Part D Prescription Drug Benefit. While designed as a way to save seniors money, and to lower government expenditures, on prescription drugs, if not implemented properly, Part D can have a devastating effect on older adults with mental illness. An anticipated way of saving money is allowing Prescription Drug Plans, or "PDPs" to determine what drugs they will provide. The financial incentive would be to include older, less effective, and lower cost mental health drugs and to exclude newer drugs that are more effective, have fewer side effects, but are more costly.

A second problem with Part D is that all "dual eligibles" must enroll in the program and must select a PDP by January 1, 2006 or they will be "randomly assigned". Many older adults with serious mental illness or cognitive impairments, such as Alzheimer's Disease, lack the capacity to make an informed decision and many of those do not have a guardian or health care representative to make a decision on their behalf. As an example let's assume that a nursing facility has 100 residents that are both Medicare and Medicaid recipients. It is likely that some of these residents will not be able to make an independent and informed selection by January 1. As these individuals are randomly assigned it is a real possibility that multiple PDPs will be assigned. Each PDP would likely offer different medications in their packages, which would seriously complicate the mental health care provided by the facility and health professionals serving the residents.

Lack of parity coverage for mental health, as compared to physical health coverage, is an enormous issue, and has not been addressed by Medicare. For example recipients must pay a fifty percent (50%) co-pay for mental health services as compared to a twenty percent (20 %) co-pay for physical health services. While some progress has been made in private sector coverage more attention is needed and the gains accomplished so far, must not be lost.

The current practice of allowing state Medicare carriers to have great latitude in establishing local coverage policy, based on their interpretation of CMS policy, is also a problem. More oversight by CMS is needed to assure consistent nationwide coverage policy.

If these and other issues presented today are to be fully addressed, older adults with mental illness and substance abuse problems must be identified as a priority at the federal level. Federal agencies must coordinate their efforts to maximize the use of available resources. Failure to do so as the population continues to grow through aging "Baby Boomers" and longer life spans, spells an even greater crisis in the years ahead. Action

on these issues at the White House Conference on Aging paired with the recommendations from the President's New Freedom Commission on Mental Health will send a strong message to policy makers across the country. We ask for your support to include these issues on the Conference agenda.